

Dr. Powell

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012966

STATE FILE NUMBER

FILED MAY 11 1959		Registration District No. 128		Primary Registration District No. 2000		Registrar's No. 448	
1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before institution) a. MISSOURI b. COUNTY GREENE			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN SPRINGFIELD 0396	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.				Length of stay in lb 12 YRS.		d. STREET ADDRESS 915 E. GRAND (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Middle Last EDNA CHLOE LIKINS				4. DATE OF DEATH Month Day Year MAY 3 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 29 1901	
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during past year, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MILLER, MISSOURI	
12. CITIZEN OF WHAT COUNTRY? USA							
13a. FATHER'S NAME CHARLES W. ARTHUR				13b. MOTHER'S MAIDEN NAME LILLIE MAY		14. NAME OF HUSBAND OR WIFE LEWIS LIKINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NO		17. INFORMANT Address LEWIS LIKINS SPRINGFIELD, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombophlebitis. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cancerous invasion of pelvic veins DUE TO (c) Squamous cell carcinoma of the cervix PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 171X						INTERVAL BETWEEN ONSET AND DEATH 2 days unborn 5 years	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from 9-25-55, to 5-3-59 and last saw her alive on 5-2-59 Death occurred at 1:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) M.B. Bonduke MD				22b. ADDRESS 304 professional Bldg. Springfield, Mo		22c. DATE SIGNED 5-4-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/5/59		23c. NAME OF CEMETERY OR CREMATORY MAPLE PARK		23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.	
24. FUNERAL DIRECTOR H.H. LOHMEYER				ADDRESS SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 5-4-59	
				26. REGISTRAR'S SIGNATURE Effie S. Melton			

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed H. J. McCune .....

Licensed Embalmer No. 2727 ....  
P. O. Address Springfield .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.